Chapter 7:

Minority Health Issues

"Injustice anywhere is a threat to justice everywhere."
Martin Luther King Jr.

"Minds are like parachutes - they only function when open."
Thomas Dewar

"Prejudice is the child of ignorance."
William Hazlitt

"You can't shake hands with a clenched fist."
Indira Gandhi

Minority Health Issues

This chapter on minority health issues will focus on groups that have traditionally been referred to as "minorities." This classification may be inappropriate and could diminish a group's important contributions to the community. Racial and ethnic categories are becoming more difficult to discern, and exclusively classifying any one person to any one group is problematic. However, it is important sometimes to classify members in the population into groups because of the various health, economic, and social issues that may be uniquely experienced by certain groups. The categories used by the federal government and the U.S. Census Bureau include White, Black, Asian, American Indian, Alaskan Native, Native Hawaiian, and other Pacific Islander. People of Hispanic or Latino ethnicity are defined as those who trace their origins to Spain, Mexico, and the Spanish-speaking nations of Central America, South America, and the Caribbean. The term Hispanic is used to describe these groups by state and some federal government publications, while other federal documents use the phrase "Hispanic or Latino." It may also be observed that there is a lack of consensus among those who trace their heritage to areas herein defined by the term Hispanic and/or Latino. In order to avoid confusion, or offending some members in the community, this chapter will identify this group as "Hispanic/Latino" for discussions and data descriptions. Similarly, the descriptors of "African American" or "Black" will also be termed "African American/Black" because of the use of different terms by various agencies as well as by members of that community.

In the fall of 2003, leaders from several groups and community organizations were invited to attend a series of meetings to promote collaborative efforts to gain support, ideas, and input from the minority communities. These community leaders were provided with health data and engaged in discussions concerning the health of these groups in Greene County. The information from this minority health issues focus group was instrumental in guiding this portion of the assessment, as well as providing valuable insight into current qualitative issues facing these communities. The African American/Black and Hispanic/Latino communities are the largest of the minority groups in Greene County and will be the main focus of this chapter. Unfortunately, because of limited data availability only certain indicators have been presented for other groups such as Asian Americans and Native Americans.

Some of the issues discussed in this chapter include: poverty, maternal and child health, chronic disease, social issues, and access to health care. Within these broader topics, several health disparities among minority groups have been noted. Some of these health disparities include:

- Poverty:
    - Minority group members carry a disproportionate amount of poverty among their families.
    - Single females with children make up a significant proportion of the total minority families living in poverty.

- Maternal and Child Health:
    - There was higher proportions of births with reported inadequate prenatal care, although this has decreased significantly since 1990.
    - There was a higher percentage of births with no prenatal care being reported.
    - There were a larger percentage of mothers with less than 12 years of education.
    - Teen (under age 18) pregnancy disproportionately affects these groups.
    - Fewer new mothers reported being married.
    - A greater proportion of mothers from minority groups reported being participants of Medicaid, food stamps, and/or WIC.
- Chronic Disease:
    - A higher percentage of deaths due to diabetes was observed in African Americans/Blacks and Hispanics/Latinos from 1997 to 2002.
    - A higher general mortality rate was observed for African Americans/Blacks.
    - Higher mortality rates for cancer and heart disease were observed among African Americans/Blacks.
- Social Issues:
    - African Americans/Blacks had a higher rate of assault injuries.
    - Native Americans reported higher rates of disabilities.
- Sexually Transmitted Infections:
    - African Americans/Blacks had higher rates of gonorrhea and chlamydia infection.
- Access to Health Care:
    - The rate of African American/Black patients utilizing county emergency rooms was double the rate of Whites.

These health disparities are important indicators of problems that are being confronted by all members of the community. But, the higher rates and proportions identified within the minority communities indicate that these groups are disproportionately burdened with these problems.

The fact that minority communities are affected disproportionately by health problems is well documented by national research. Because of this, it became imperative to begin a process to identify and define these issues, as well as seek input from the members of these communities. The purpose of this chapter is to further this process by providing a foundation for discussions and strategic planning among community leaders and agencies. It is hoped that this continuing process will help to decrease the health disparities that exist in the county. This chapter is only a starting point, from which everyone in Greene County will hopefully benefit.

Minority Health Issues

Did You Know?

- The Hispanic/Latino population recorded the greatest percent increase (149.8%) in population among all racial and ethnic groups in Greene County from 1990 to 2000.

- African American/Black residents make up 2.3% (5,426) of the population of Greene County and 11% (629,391) of Missouri's population.

- Hispanic/Latino residents make up 1.8% (4,434) of the population of Greene County and 2.1% (118,592) of Missouri's population.

- People of color make up 2/3 of the world's population, making Whites the minority worldwide.

- 1 in 5 Americans speaks Spanish.

- From 1990 to 2000 the Asian American and Pacific Islander population of Greene County increased by more than 88.1% to 2,865 residents.

Minority Health Issues

Background

The population of Greene County and Southwest Missouri is becoming more diverse. From 1990 to 2000, the census recorded substantial increases in population among the African American (44%), Hispanic/Latino (149.8%), and AAPI (Asian American, Pacific Islanders) (88.1%). This section of the community health assessment will focus on some of the major issues affecting the racial and ethnic minority groups in the county. By doing so, community planners will gain a better understanding of current issues to assist strategic planning and public policy. Input and support from community leaders participating in the focus groups are vital to help guide and increase understanding of these important issues. Continued input from the minority communities will help to develop successful services and programs that are culturally sensitive and address community needs.

Numerous researchers in larger national studies have shown that socioeconomic considerations are intimately related to health status. Any person or group, regardless of race or ethnicity, can have negative health consequences when poverty, unemployment, and lack of education prevent them from obtaining needed healthcare. Data presented in this chapter indicate that these minority community members experience negative health consequences and social disparities such as poverty and unemployment. Health disparities mentioned in the previous section are the result of complex interactions that have developed because of historic, socioeconomic, cultural, and institutionalized factors that exist. Some of these health disparities have a more apparent relationship to socioeconomic status than others. Furthermore, other social determinants such as gender, education, marital status, social class, or geographic differences contribute to inequities and are much more difficult to understand or quantify. Because of this, it is important to realize that many interactions exist between the various health indicators, socioeconomic conditions, cultural experiences, and social determinants in the community.

To gain an additional perspective on issues confronting the racial and ethnic minority communities in the county, qualitative information was obtained concerning barriers to health care services and access to care. Discussions during the minority health issues focus group helped to reveal several issues that would not have been realized by reviewing the numerical data alone. Several items discussed during the focus group related to psychological barriers and institutional characteristics that limited or prevented some members of the minority community from readily receiving or seeking health care services.

Psychological barriers are real barriers that can prevent people from pursuing what they need, or achieving all that they can. One of the psychological barriers identified for some community members involves what is considered the “North-side” and “South-side” of the City of Springfield. This mental barrier results in negative stereotypes and some people feeling uncomfortable or perceiving themselves as being “out-of-place” when going to unfamiliar areas of the city or even sitting in a doctor’s office. Members of minority groups are even more affected by this barrier since these groups make up a small percentage of the total population and may feel increasingly scrutinized in certain areas. This “North-side” and “South-side” barrier becomes more problematic to those seeking medical treatment since a significant portion of the health care facilities are located on the southern side of the city. Consequences of this could

include a delay in seeking treatment in order to avoid anxiety associated with traveling to unfamiliar areas of the city.

Uncomfortable perceptions associated with feeling "out-of-place" in the health care setting may be exacerbated by the lack of health care professionals from minority groups. Distrust of the health care system has been cited to exist among some minority community members, who are confronted by a health care system that is predominantly represented by Whites. Miscommunication, misunderstandings, and failures to relate to one another may have helped create a situation that alienates some members of the minority community. These factors may inadvertently foster some cultural and psychological barriers, as health care workers may be more willing to interact more readily with those patients whom they perceive as being similar to themselves. Consequently, this may significantly influence the decision of when to seek or access health care services in the future.

Concerns surrounding access and seeking of health care are compounded by the fact that many individuals, regardless of race or ethnicity, from lower socioeconomic and increasingly middle class strata, confront a health care system that is constantly becoming more complex and unintelligible. Many people lack the knowledge to ask questions and competently interact within this complex system possibly resulting in an institutionalized-psychological barrier. Inability to comprehend the system may cause frustration and further misunderstandings. These factors may affect access to health care for some minority group members as patients and health care providers from different racial and ethnic backgrounds communicate ineffectively when developing treatment plans that will be followed or afforded.

Access to health care is also an institutionalized barrier as disadvantaged residents with Medicaid insurance find it difficult to locate non-emergency health care services. One reason for this is that physicians must limit Medicaid patients because of increasing health care costs and/or reimbursement issues. This affects minority groups disproportionately because the percentage of those eligible for Medicaid is higher compared to the White population. As a result, even though these individuals may have health insurance through Medicaid, finding a primary care physician and receiving treatment early in the disease process can be challenging.

Another institutionalized barrier that may impact the seeking of health care, involves transportation issues. There is a common misperception that this problem is addressed by use of the public transportation system. For many disadvantaged members of the community this transportation system does not adequately address their needs because of inconvenience and confusion concerning the system. Because racial and ethnic minority groups in the county have a significant proportion of poverty burden, more of their members may cope with these difficulties in addition to their health concerns. People living in poverty who cannot afford private transportation may postpone seeking treatment until absolutely necessary. This could result in increased severity of disease requiring more intense and costly treatment.

For the non-English speaking members of the community, institutionalized barriers seem to discourage the use of public transportation as well as the utilization of health care services. Institutionalized language barriers are continued sources of stress that affect many different groups in the community. During the minority health focus group meetings it was observed that many Hispanic/Latino residents rely on family and

friends to provide or translate health information, because of cultural differences and language barriers. This is becoming more of a concern because of the recent growth in the number of Hispanic/Latino families. These families have health care needs that are different than those of the single men who comprised the initial influx of Hispanic/Latino immigrants. The language barrier confronts other non-English speaking immigrants who need health care in the county as well. Language difficulties will result in health disparities as non-English speaking residents postpone treatment or do not understand treatment instructions.

Other areas of concern include gaps in knowledge of the current health status of the minority communities in the county. Behavioral risk factor assessment surveys gather information on lifestyle factors that affect health such as smoking, exercise, obesity, and diet. Many of these surveys routinely collect data on a regional or county level for the entire population without distinguishing between racial or ethnic categories. Because the population in Greene County is over 90% White, the data collected during these surveys is predominately representative of the White community. These surveys fail to recognize and assess the health status or risk factors present in the minority populations. Consequently, the risk factors that negatively affect the health of minority members in the community are not being determined and prevention efforts are not being implemented, which may ultimately result in health disparities.

Solutions to some of the problems affecting the minority communities in Greene County involve socioeconomic issues. The health disparities created by poverty are troublesome for all of the disadvantaged residents of the county. But, because minority groups carry a greater proportional burden of poverty (Table 7.5, Figure 7.1a and b), more of their members are affected by the problems discussed. Solutions to address specific barriers to health care are practical and can be accomplished. Some solutions of the problems mentioned earlier include:

- The recruitment of more health care providers who are from different racial and ethnic backgrounds
- Education concerning cultural differences
- More primary care access for Medicaid patients
- Education for patients regarding basic health care system issues
- Hiring of more interpreters (Spanish, Vietnamese, Chinese, etc.)
- More signs in hospitals and clinics that provide translations
- A Behavioral Risk Factor Survey of the minority populations in Greene County
- More outreach activities by public health officials

These problems and suggested solutions are not meant to be a definitive description on how to address or solve the problems facing the community. This health assessment process is only the first step in a community-wide process that will continue with discussions and planning.

Demographics

The demographic profile of the population in Greene County from the 2000 Census is shown in Tables 7.1 to 7.4. The racial and ethnic percentages for groups within the total population of Greene County are listed in Table 7.1. The minority population in the county continues to represent a small proportion of the total population. However, as seen in Table 7.2, the percent increases for racial groups other than White in Greene County were substantial. For example, the African American/Black population increased by over 44% and the Asian American, Pacific Islander population increased 88.1% from 1990 to 2000.

Table 7.1

Percent of Total Population For Racial and Ethnic Groups-Greene County, 2000*						
	White	**African American/Black**	**Native American /Alaskan Native**	**Hispanic/ Latino**	**Asian, Pacific Islander**	**Other**
Greene	92.5	2.3	0.7	1.8	1.2	0.7
Missouri	83.8	11.2	0.4	2.1	1.2	0.8

Source: U.S. Bureau of the Census, 2000

*Population percentages do not total 100% because of the differences in ethnicity and racial definitions and calculations

Table 7.2

Percent of Population Increases-Greene County, 1990-2000				
White	**African American/Black**	**Native American /Alaskan Native**	**Hispanic/ Latino**	**Asian, Pacific Islander**
11.9	44.7	23.6	149.8	88.1

Source: U.S. Bureau of the Census, 2000

The greatest percent increase for any group was seen in the Hispanic/Latino population. The numbers for different Hispanic/Latino groups is indicated in Table 7.3, as well as the percent of change from 1990. The 149.8% increase in total numbers is significant, but total representation in the population is still low.

Table 7.3

Hispanic/Latino Groups-Greene County, 1990-2000					
	Total	**Mexican**	**Puerto Rican**	**Cuban**	**Other**
1990	1,775	911	183	58	726
2000	4,434	2,594	381	110	1,349
Percent Change	149.8	184.7	108.2	89.7	85.8
Percent of Total Population Year 2000	1.84	1.07	0.15	0.05	0.56

Source: U.S. Bureau of the Census, 2000

Table 7.4 shows some characteristics of the population, by race and ethnicity. The median age for the White population is significantly higher than the other racial and ethic groups.

Table 7.4

Demographic Characteristics by Race or Ethnicity-Greene County, 2000					
	White	**African American/ Black**	**Native American /Alaskan Native**	**Hispanic /Latino**	**Asian American**
Average Family Size	2.87	3.22	3.12	3.48	3.46
Average Household Size	2.32	2.53	2.53	2.87	2.81
Median Age	36.0	27.6	30.4	23.5	29.5
Unmarried Partner Households (Percent of total Households)	5.0	8.8	10.2	9.2	3.7

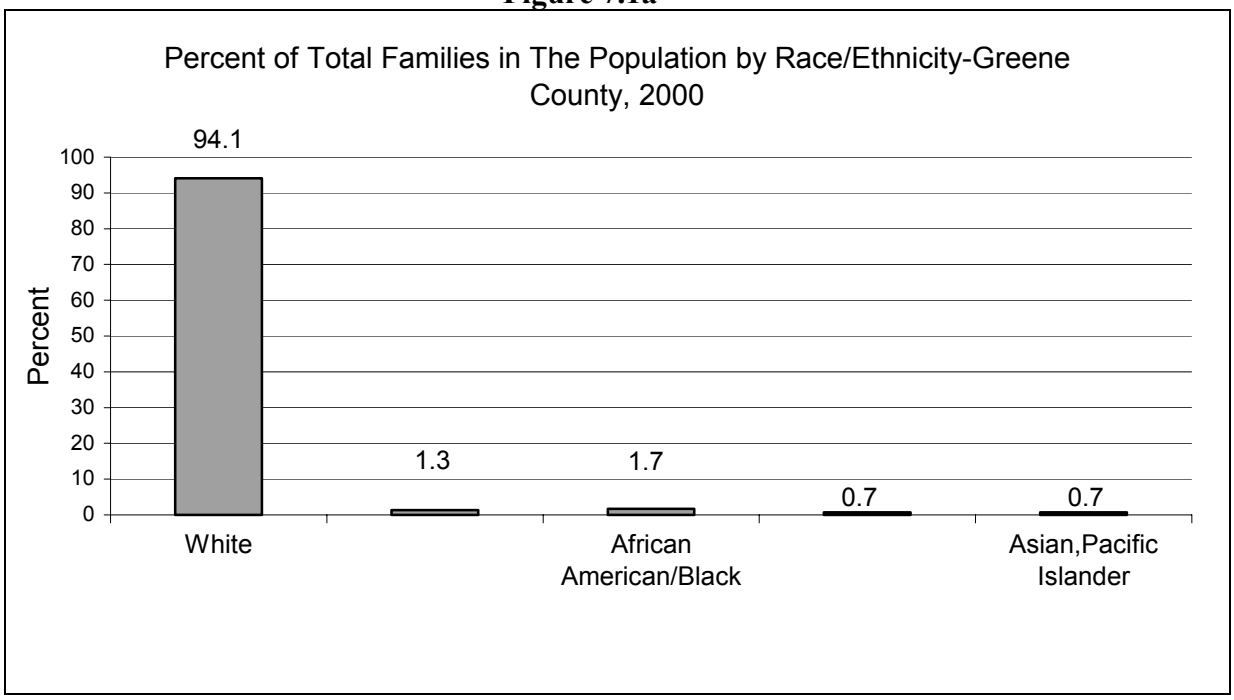
Source: U.S. Bureau of the Census, 2000

Poverty

A comparison of the distribution of poverty among the various racial and ethnic groups in the county is illustrated in Figures 7.1a and 7.1b. Through this comparison it can be seen that while minority groups continue to represent small proportions of the total population (Figure 7.1a), the percentage of families who are living in poverty is significantly higher (Figure 7.1b). This disparity is even more startling when compared to White families, who have a relatively small percentage of their families living in poverty. Table 7.5 lists the numerical values of this data.

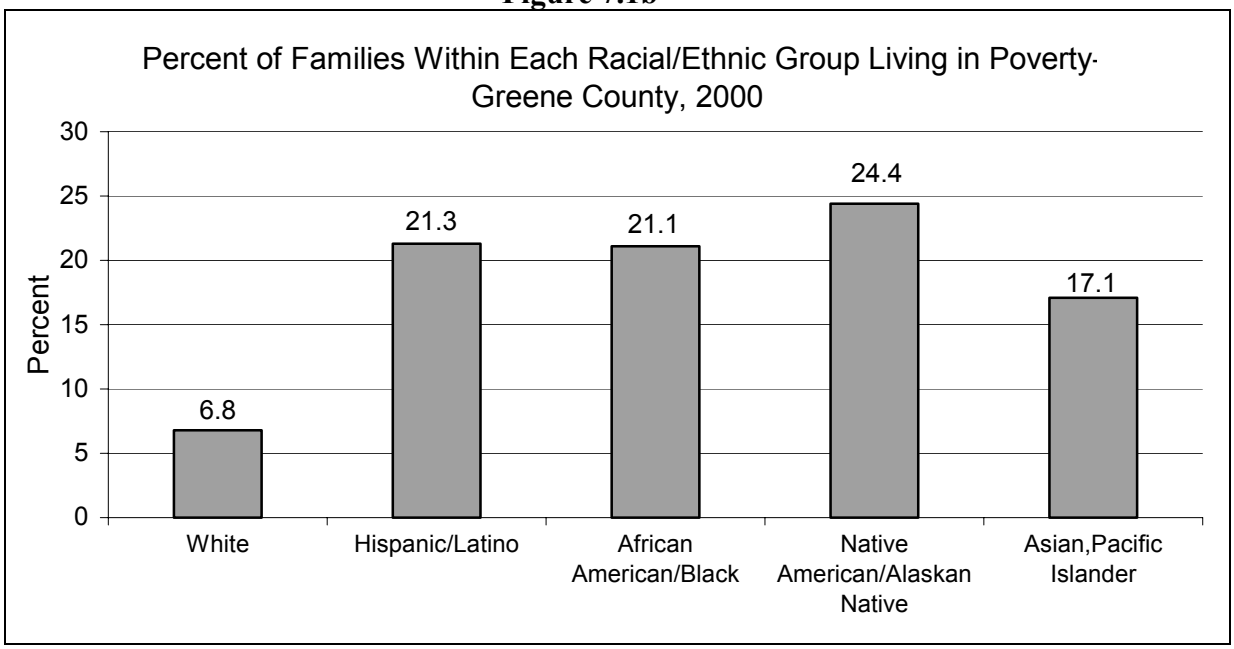
An analysis of recent national economic data has indicated that the poverty rate for African American/Black families rose substantially faster compared to other racial groups. This research also observed that African American/Black married families with children also had a dramatic increase in the rates of poverty from 2000 to 2001 (Harrison 2003).

Figure 7.1a



Source: U.S. Bureau of the Census, 2000; n=62,147

Figure 7.1b



Source: U.S. Bureau of the Census, 2000

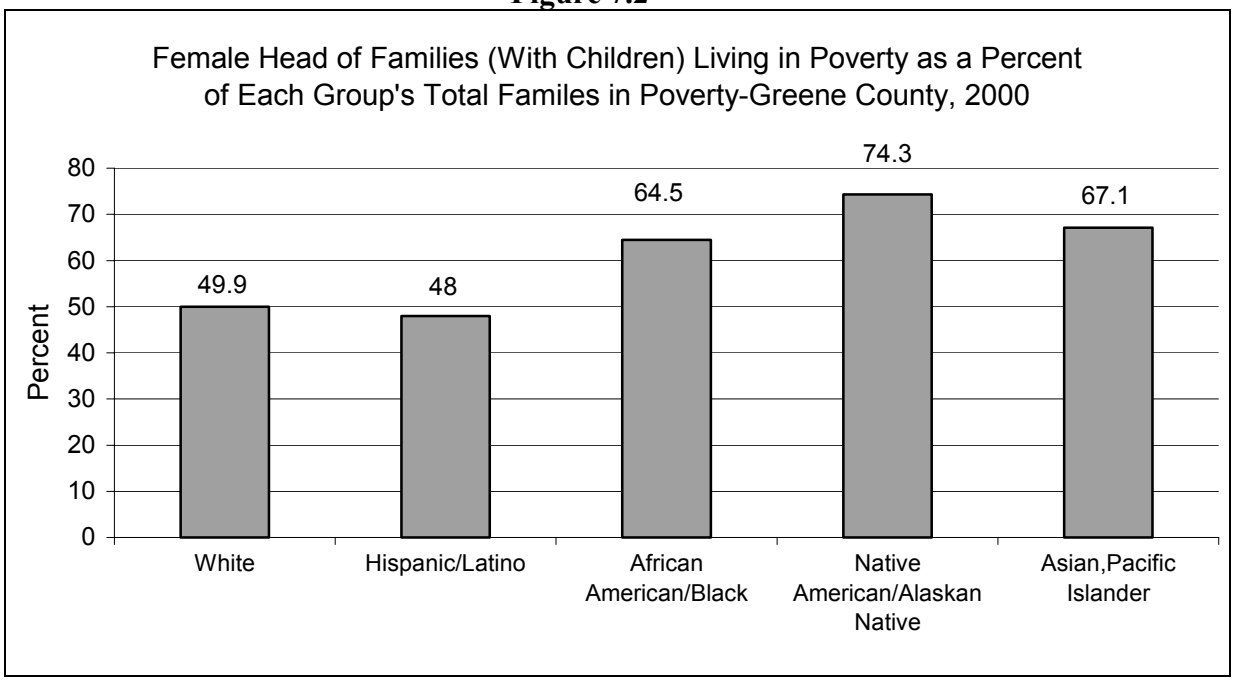
Table 7.5

Families Living Below Poverty Levels-Greene County, 2000						
	Total	**White**	**Hispanic/ Latino**	**African American/ Black**	**Native American /Alaskan Native**	**Asian, Pacific Islander**
Total Families	62,147	58,471	831	1,077	431	427
Percent of Families Below Poverty Levels Within Group	7.5	6.8	21.3	21.1	24.4	17.1

Source: U.S. Bureau of the Census, 2000

Poverty among single mothers is a problem for all groups as seen in Figure 7.2. Single mothers represent the majority of families in poverty for the total population. This is supported by research, which has also indicated that women of color experience even greater economic difficulties. Employment, family structure, and immigration status were possible factors that could help to explain these differences (Elmelech and Hsien-He 2004).

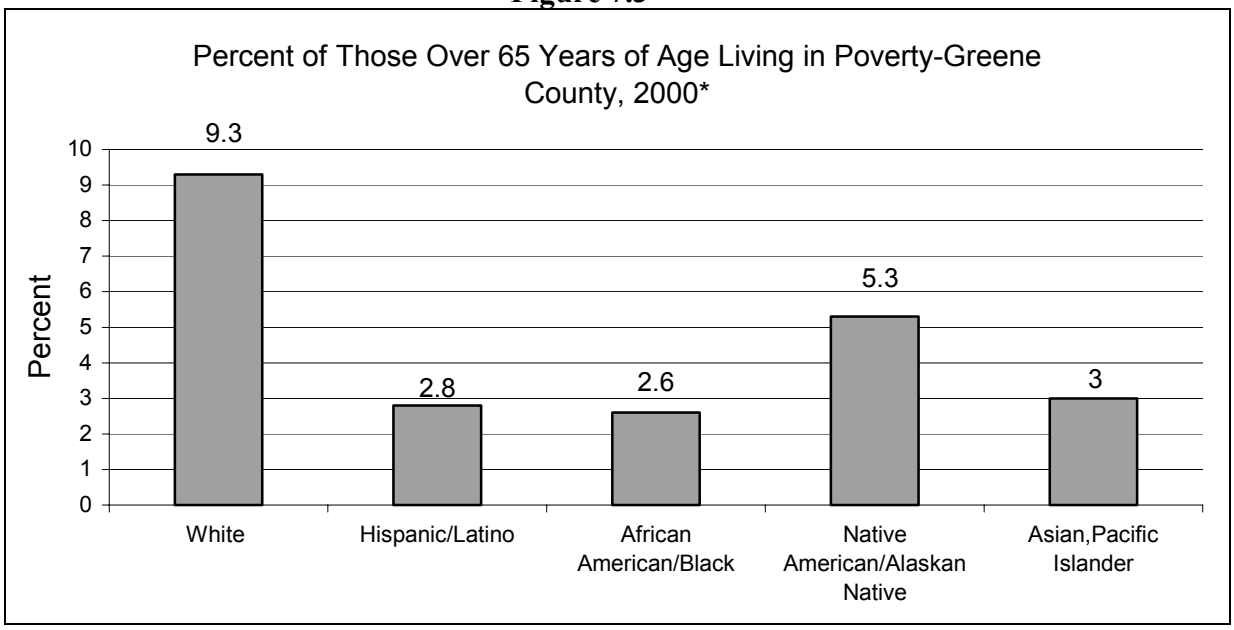
Figure 7.2



Source: U.S. Bureau of the Census, 2000

Poverty characteristics for different age groups according to race and ethnicity are indicated in Figure 7.3 and Table 7.6. The White population has a substantially greater number of seniors living in poverty as compared to the other groups. Figure 7.3 shows the proportion of those in poverty who are seniors within each racial or ethnic group.

Figure 7.3



Source: U.S. Bureau of the Census, 2000

*For each group n= total number of persons over 65 years of age in that particular group living in poverty; see Table 7.6 for values.

Table 7.6

Poverty Status by Age-Greene County, 2000						
	Total All Races	**White**	**Hispanic /Latino**	**African American/ Black**	**Native American/Alaskan Native**	**Asian, Pacific Islander**
Under 5	2,424	1,736	150	246	35	23
5 Years	434	380	33	9	0	0
6 to 11	2,260	1,800	132	138	51	55
12 to 17	2,214	1,747	92	154	107	54
18-64	17,971	15,587	472	742	324	325
65 to 74	1,011	915	14	19	18	9
Over 75	1,316	1,260	11	16	11	5
Total	27,630	23,425	904	1,324	546	471

Source: U.S. Bureau of the Census, 2000

Another concern is the number of children and adolescents living in poverty among all groups (Table 7.6). A large proportion (26.5%) of those who were living in poverty in the year 2000 were under 18 years of age.

Socioeconomic characteristics such as unemployment and highest educational attainment within racial or ethnic groups are indicated in Table 7.7. All groups in the minority community reported greater unemployment than the Greene County White population according to the information provided in the year 2000 census.

Table 7.7

Socioeconomic Characteristics by Race and Ethnicity-Greene County, 2000						
	Unemployment (%)	**Highest Educational Attainment for Those Over 25 Years of Age (%)***				
	Unemployed Workers	**<12 Years of Education**	**High School Grad. Or Equivalent**	**Some College, No Degree**	**College Degree (Associates or Bachelors)**	**Graduate Degree**
White (Not Hispanic/Latino)	**5.1**	**14.8**	**31.0**	**25.1**	**20.7**	**8.4**
Male	5.2	13.9	30.9	24.7	21.0	9.4
Female	5.0	15.6	31.1	25.5	20.3	7.5
African American/Black	**11.5**	**15.8**	**35.9**	**28.0**	**18.1**	**2.1**
Male	10.6	17.0	39.7	24.9	17.0	1.4
Female	12.8	13.9	29.2	33.4	20.1	3.4
Asian American	**7.4**	**20.0**	**18.1**	**13.7**	**36.9**	**11.3**
Male	8.4	22.7	18.6	12.6	35.7	10.3
Female	6.5	18.2	17.8	14.4	37.7	12.0
Native American/Alaskan Na.	**16.5**	**26.1**	**21.7**	**31.4**	**10.0**	**6.0**
Male	13.2	28.1	22.5	36.3	11.1	1.9
Female	20.0	23.9	20.8	25.9	8.7	10.7
Hispanic/Latino	**10.9**	**28.5**	**29.4**	**20.1**	**15.2**	**6.8**
Male	12.1	29.7	28.8	20.6	16.6	4.4
Female	9.2	27.0	30.2	19.4	13.4	9.9

Source: US Census Bureau, 2000; Summary File 3

*Gender data represents percentage within gender group; n=number of males or females

Maternal and Child Health

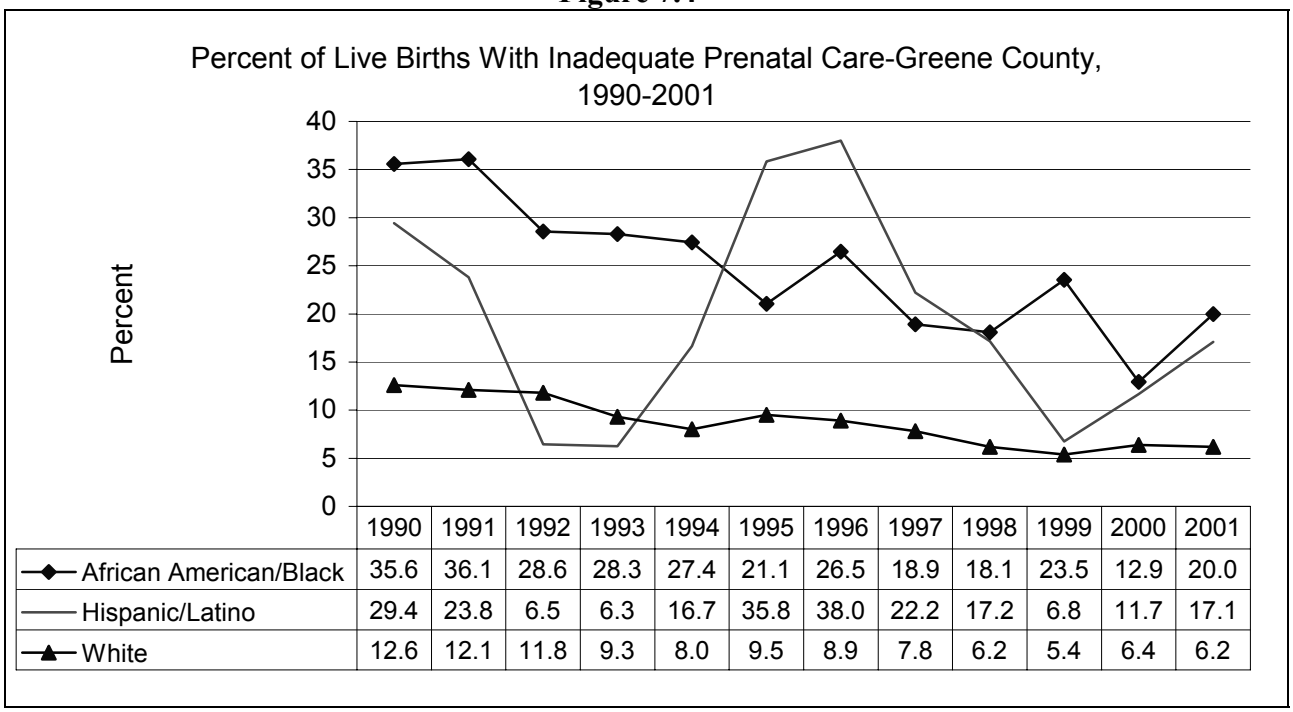
Prenatal Care is examined in Figures 7.4 and 7.5 and Table 7.8. Inadequate prenatal care is defined as less than 5 doctor office visits for pregnancies of less than 37 weeks, or less than 8 visits for pregnancies of 37 weeks or longer, or care beginning after the 4th month of pregnancy.

The percent of births with inadequate prenatal care is decreasing for the African American/Black population, but still remains significantly higher than what is seen among the White population. Some researchers have observed a similar trend in other locations, with low utilization of prenatal care among African Americans/Blacks (Herbst et al. 2003).

The trend line among the Hispanic/Latino community has fluctuated greatly from 1990 to 2001. Low population numbers are primarily responsible for these fluctuations. The method of rate calculation is very sensitive and is affected by low population and birth numbers. However, some concern was voiced during the minority health focus group meetings that some barriers might exist that hinder utilization of some of these services, i.e. language barriers, distrust of system, and transportation. Further investigation is warranted to determine how to increase utilization of prenatal care for all groups.

A decreased likelihood of entering into prenatal care among all women has been associated with women who live in inadequate housing, smoked tobacco, or used alcohol and/or drugs. The risk factor that significantly reduced early entry into prenatal care, among all racial groups, was whether or not the pregnancy was wanted (Pagnini and Reichman 2000).

Figure 7.4



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
African American/Black	35.6	36.1	28.6	28.3	27.4	21.1	26.5	18.9	18.1	23.5	12.9	20.0
Hispanic/Latino	29.4	23.8	6.5	6.3	16.7	35.8	38.0	22.2	17.2	6.8	11.7	17.1
White	12.6	12.1	11.8	9.3	8.0	9.5	8.9	7.8	6.2	5.4	6.4	6.2

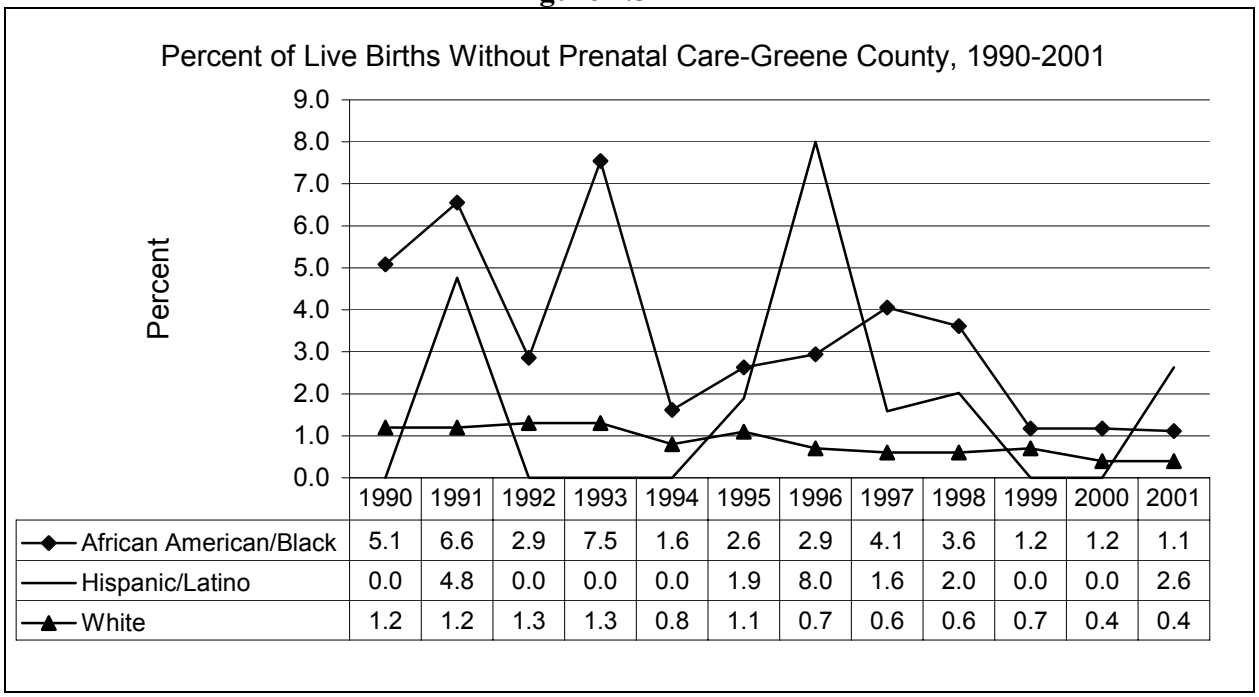
Source: Missouri Department of Health and Senior Services

Table 7.8

Number of Births Reported With Inadequate Prenatal Care-Greene County, 1997-2001				
	1997	**1999**	**2001**	**5 Year Mean**
African American/Black	14	20	18	16
Hispanic/Latino	14	5	13	11
White	221	161	174	186
Native American/Alaskan Native	*	*	*	4
Asian, Pacific Islander	*	*	*	8

Source: Missouri Department of Health and Senior Services
*The low numbers of births each year prevents the release of data by the state because of confidentiality rules

Figure 7.5

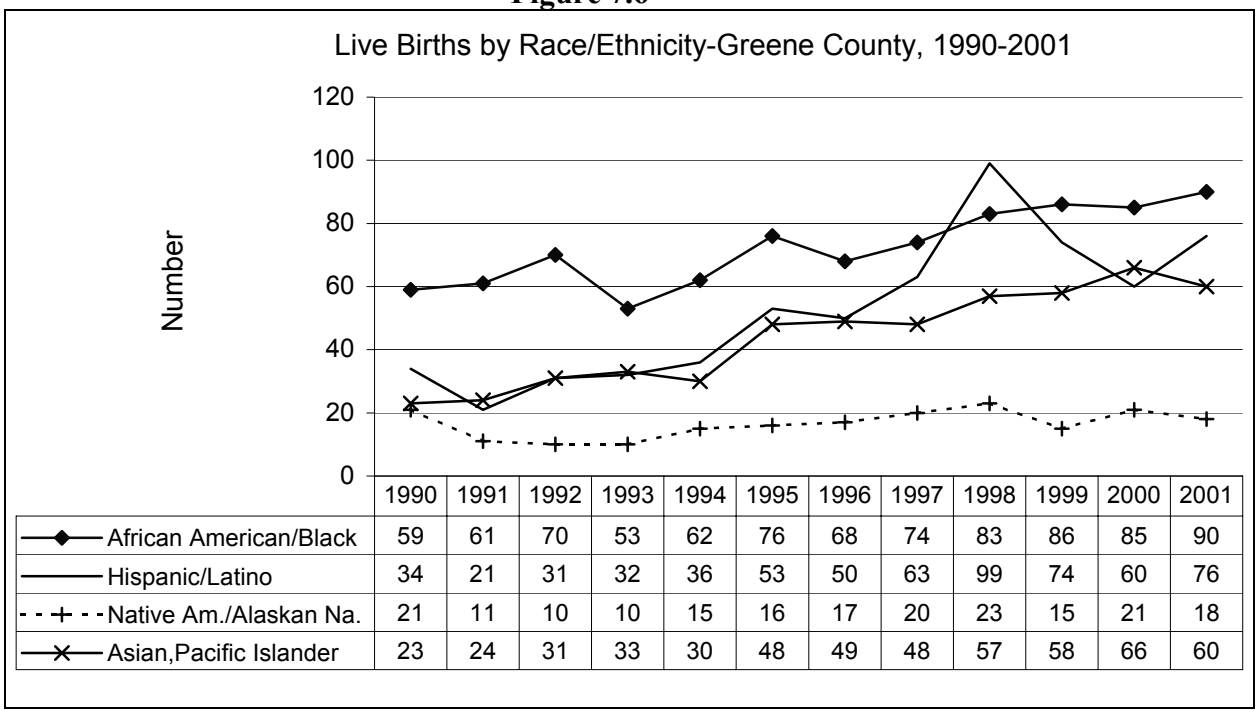


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
African American/Black	5.1	6.6	2.9	7.5	1.6	2.6	2.9	4.1	3.6	1.2	1.2	1.1
Hispanic/Latino	0.0	4.8	0.0	0.0	0.0	1.9	8.0	1.6	2.0	0.0	0.0	2.6
White	1.2	1.2	1.3	1.3	0.8	1.1	0.7	0.6	0.6	0.7	0.4	0.4

Source: Missouri Department of Health and Senior Services

Total live births for several groups from 1990 to 2001 are shown in Figure 7.6. The numbers of annual births for each group has been increasing overall.

Figure 7.6



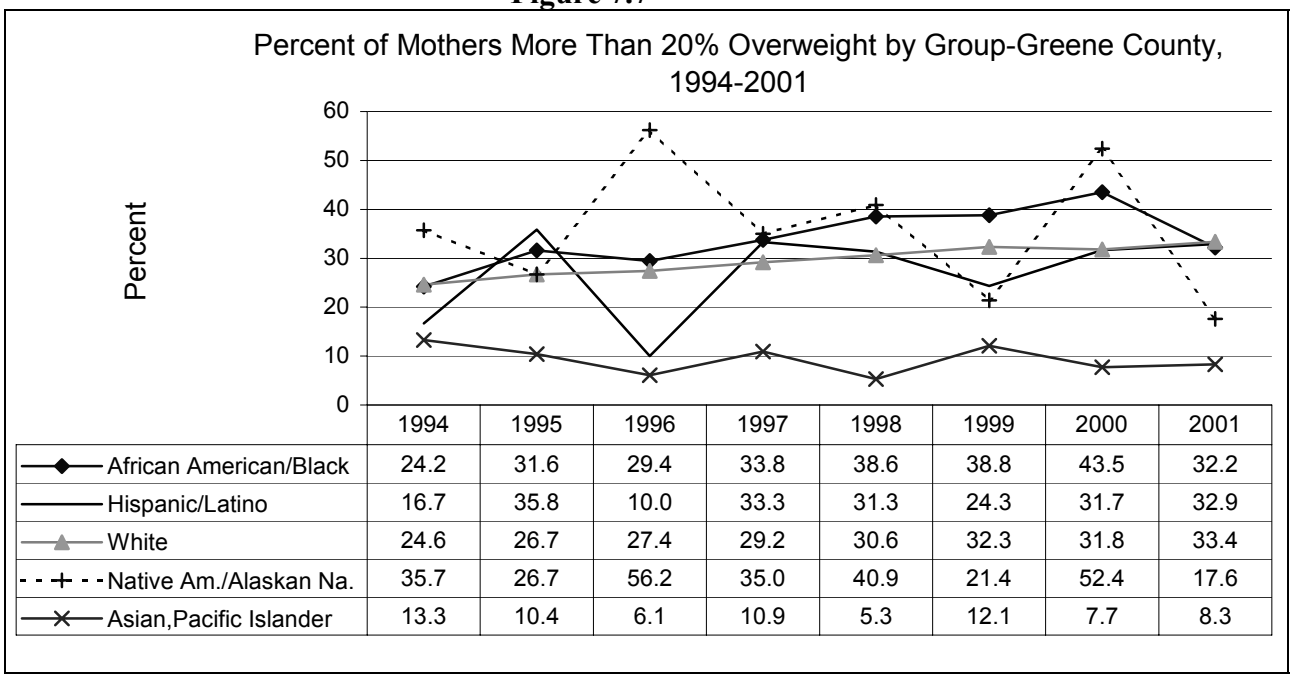
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
African American/Black	59	61	70	53	62	76	68	74	83	86	85	90
Hispanic/Latino	34	21	31	32	36	53	50	63	99	74	60	76
Native Am./Alaskan Na.	21	11	10	10	15	16	17	20	23	15	21	18
Asian,Pacific Islander	23	24	31	33	30	48	49	48	57	58	66	60

Source: Missouri Department of Health and Senior Services

Another area of concern in all segments of the community is the increasing prevalence of overweight and obese persons. Figure 7.7 illustrates an increasing trend in mothers who are more than 20% over their ideal body weight. In most groups an increase in the number of overweight mothers has been observed since 1994. The largest overall increase in the percentage of overweight mothers per births has been seen in White and Hispanic/Latino mothers. It is also important to note that because of the low numbers of annual births for some groups, the calculated trends will be unstable, and large fluctuations will appear to be occurring when the data is plotted.

Obesity is a significant threat to public health nationally and locally. Race, socioeconomic status, and health insurance status have been examined in regards to child and adolescent risk of being overweight. The researchers found that minority children and adolescents were more likely to be overweight compared to their white peers (Haas et al. 2003). In adolescents, a significant relationship was observed between being overweight and lacking health insurance, or being on public insurance, independent of minority status (Haas et al 2003). Another national study observed that self-evaluations of perceived weight appropriateness varied by age, gender, race, marital status, education, and income (Chang and Christakis 2003).

Figure 7.7

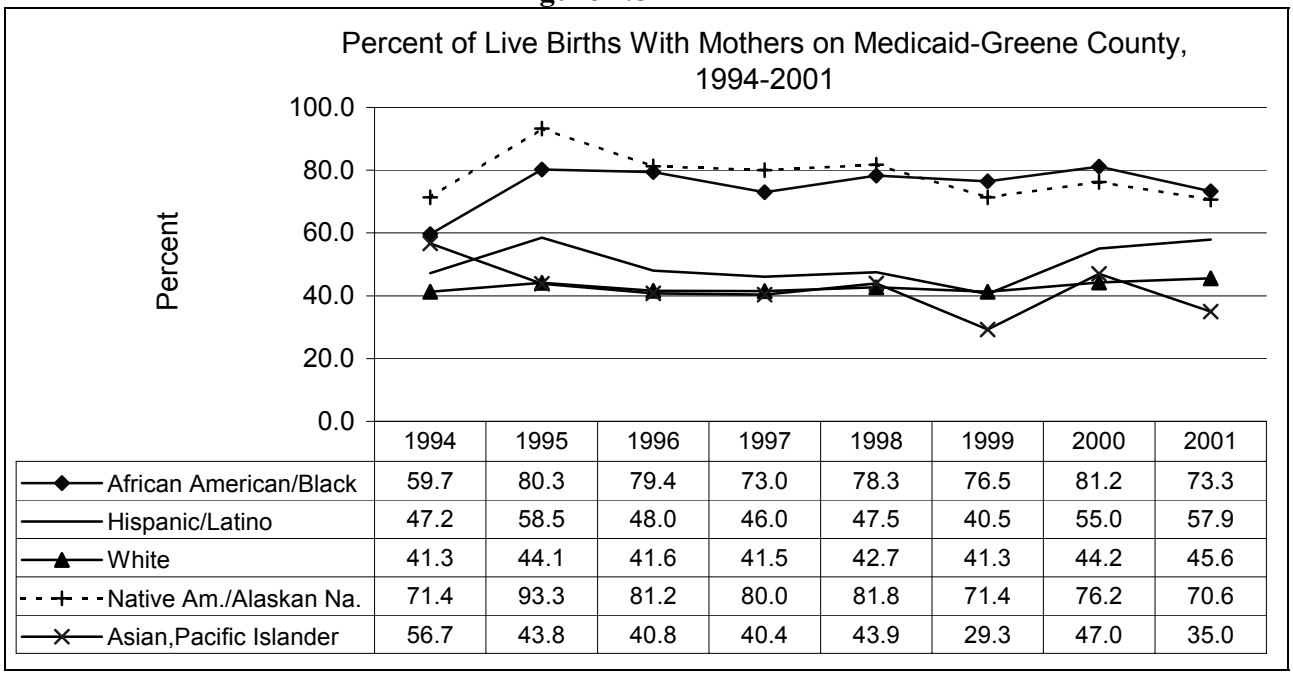


	1994	1995	1996	1997	1998	1999	2000	2001
African American/Black	24.2	31.6	29.4	33.8	38.6	38.8	43.5	32.2
Hispanic/Latino	16.7	35.8	10.0	33.3	31.3	24.3	31.7	32.9
White	24.6	26.7	27.4	29.2	30.6	32.3	31.8	33.4
Native Am./Alaskan Na.	35.7	26.7	56.2	35.0	40.9	21.4	52.4	17.6
Asian,Pacific Islander	13.3	10.4	6.1	10.9	5.3	12.1	7.7	8.3

Source: Missouri Department of Health and Senior Services

The percent of live births with mothers on Medicaid is shown in Figure 7.8. All groups have shown increases in utilization of Medicaid since 1990. Similar trends are seen with utilization of the WIC program (Figure 7.9). These differences in utilization of programs are similar to what was observed in recent research, which indicates that perceptions of "socially acceptable" programs vary by race and age (Martin et al. 2003).

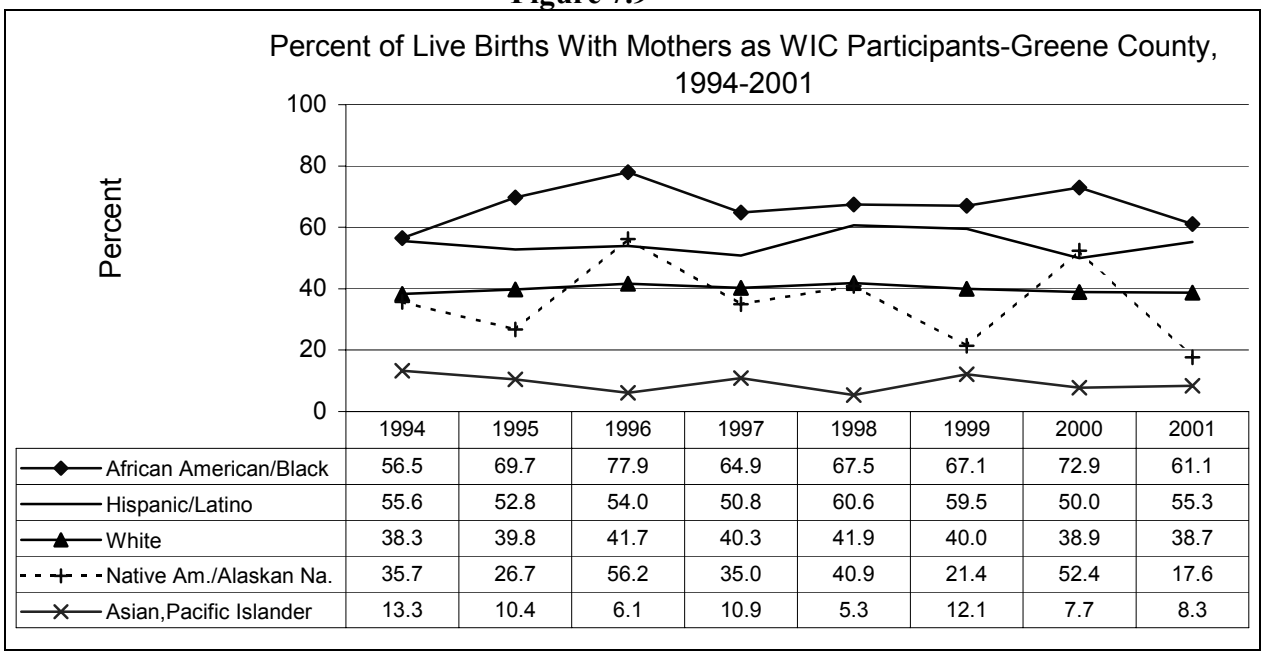
Figure 7.8



	1994	1995	1996	1997	1998	1999	2000	2001
African American/Black	59.7	80.3	79.4	73.0	78.3	76.5	81.2	73.3
Hispanic/Latino	47.2	58.5	48.0	46.0	47.5	40.5	55.0	57.9
White	41.3	44.1	41.6	41.5	42.7	41.3	44.2	45.6
Native Am./Alaskan Na.	71.4	93.3	81.2	80.0	81.8	71.4	76.2	70.6
Asian,Pacific Islander	56.7	43.8	40.8	40.4	43.9	29.3	47.0	35.0

Source: Missouri Department of Health and Senior Services

Figure 7.9

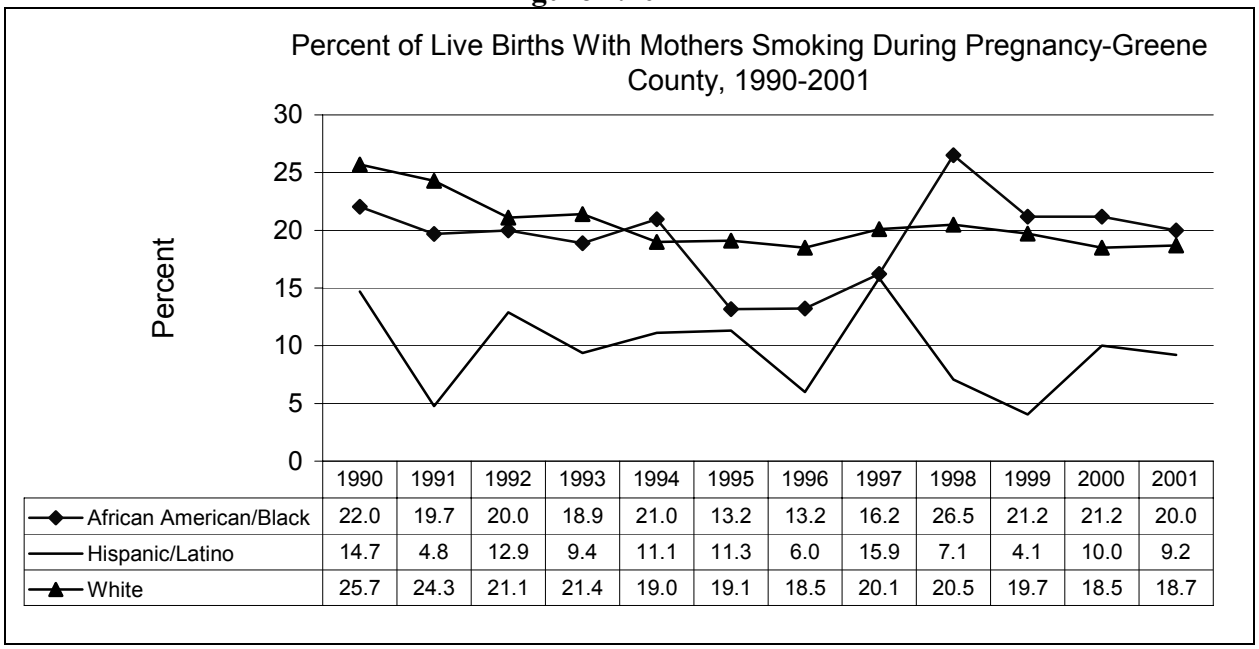


	1994	1995	1996	1997	1998	1999	2000	2001
African American/Black	56.5	69.7	77.9	64.9	67.5	67.1	72.9	61.1
Hispanic/Latino	55.6	52.8	54.0	50.8	60.6	59.5	50.0	55.3
White	38.3	39.8	41.7	40.3	41.9	40.0	38.9	38.7
Native Am./Alaskan Na.	35.7	26.7	56.2	35.0	40.9	21.4	52.4	17.6
Asian,Pacific Islander	13.3	10.4	6.1	10.9	5.3	12.1	7.7	8.3

Source: Missouri Department of Health and Senior Services

Tobacco smoke has been found to cause numerous forms of cancer, exacerbate respiratory illnesses such as asthma, and contribute to low-birth weight. Figure 7.10 indicates that a slight decrease in the percentage of expectant mothers who smoke has occurred since 1990. However, close to 20% of White and African American/Black expectant mothers in the community continue to smoke. The percentage of Hispanic/Latino expectant mothers who smoke continues to be less than other groups.

Figure 7.10

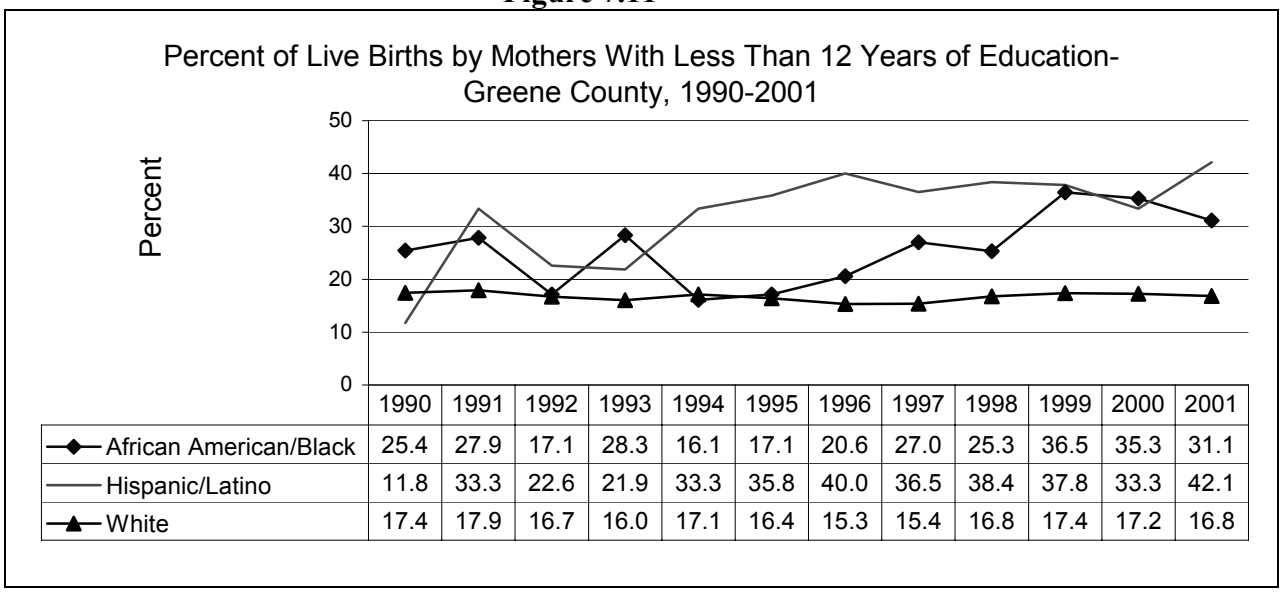


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
African American/Black	22.0	19.7	20.0	18.9	21.0	13.2	13.2	16.2	26.5	21.2	21.2	20.0
Hispanic/Latino	14.7	4.8	12.9	9.4	11.1	11.3	6.0	15.9	7.1	4.1	10.0	9.2
White	25.7	24.3	21.1	21.4	19.0	19.1	18.5	20.1	20.5	19.7	18.5	18.7

Source: Missouri Department of Health and Senior Services

The percent of mothers with less than 12 years of education is presented in Figure 7.11. An increasing trend is present in Hispanic/Latino and African American/Black mothers. The percentage of White mothers has remained relatively constant since 1990. White teens continue to comprise the vast majority of teen births as seen in Figure 7.12, with over 90% of all teen births being to White mothers. However, when rate and percent comparisons are made, the African American/Black and Hispanic/Latino mothers who are under age 18 comprise a larger proportion of births for their group as illustrated in Figures 7.14 and have higher rates of teen births as shown in Figure 7.13.

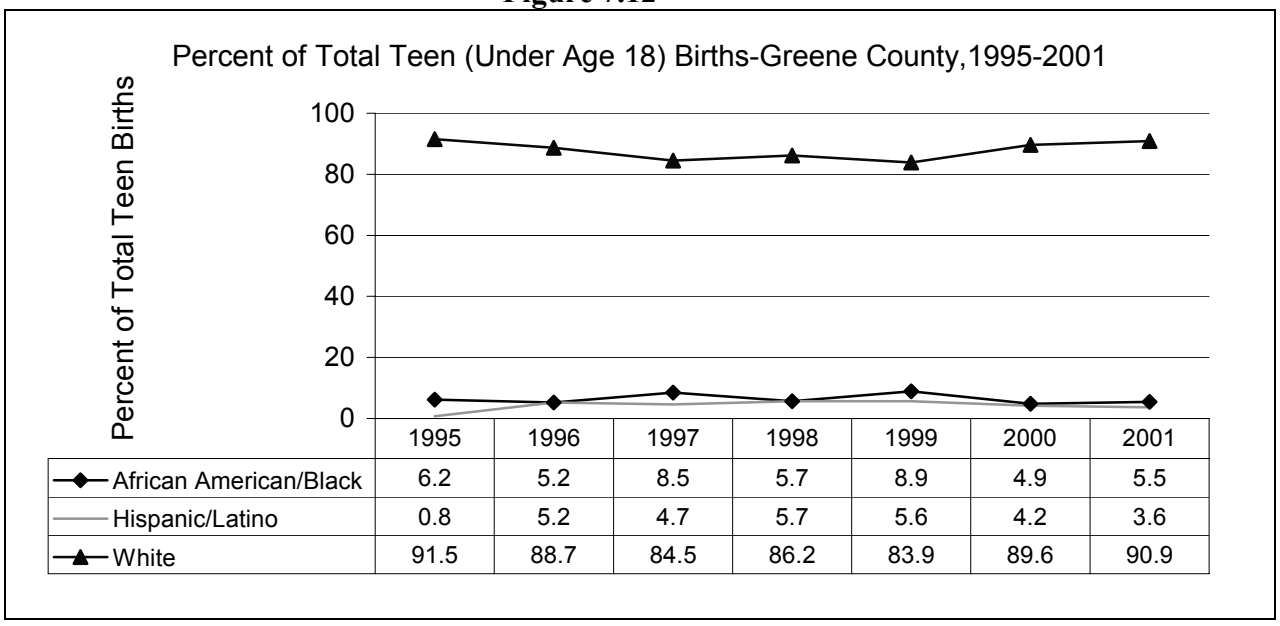
Figure 7.11



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
African American/Black	25.4	27.9	17.1	28.3	16.1	17.1	20.6	27.0	25.3	36.5	35.3	31.1
Hispanic/Latino	11.8	33.3	22.6	21.9	33.3	35.8	40.0	36.5	38.4	37.8	33.3	42.1
White	17.4	17.9	16.7	16.0	17.1	16.4	15.3	15.4	16.8	17.4	17.2	16.8

Source: Missouri Department of Health and Senior Services

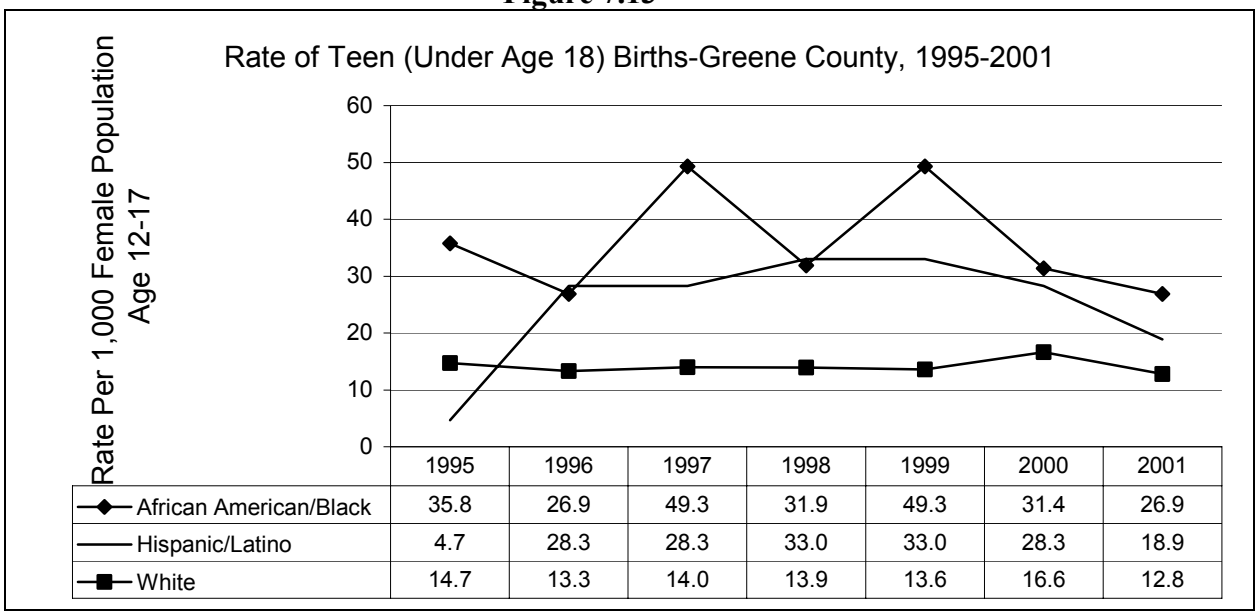
Figure 7.12



	1995	1996	1997	1998	1999	2000	2001
African American/Black	6.2	5.2	8.5	5.7	8.9	4.9	5.5
Hispanic/Latino	0.8	5.2	4.7	5.7	5.6	4.2	3.6
White	91.5	88.7	84.5	86.2	83.9	89.6	90.9

Source: Missouri Department of Health and Senior Services

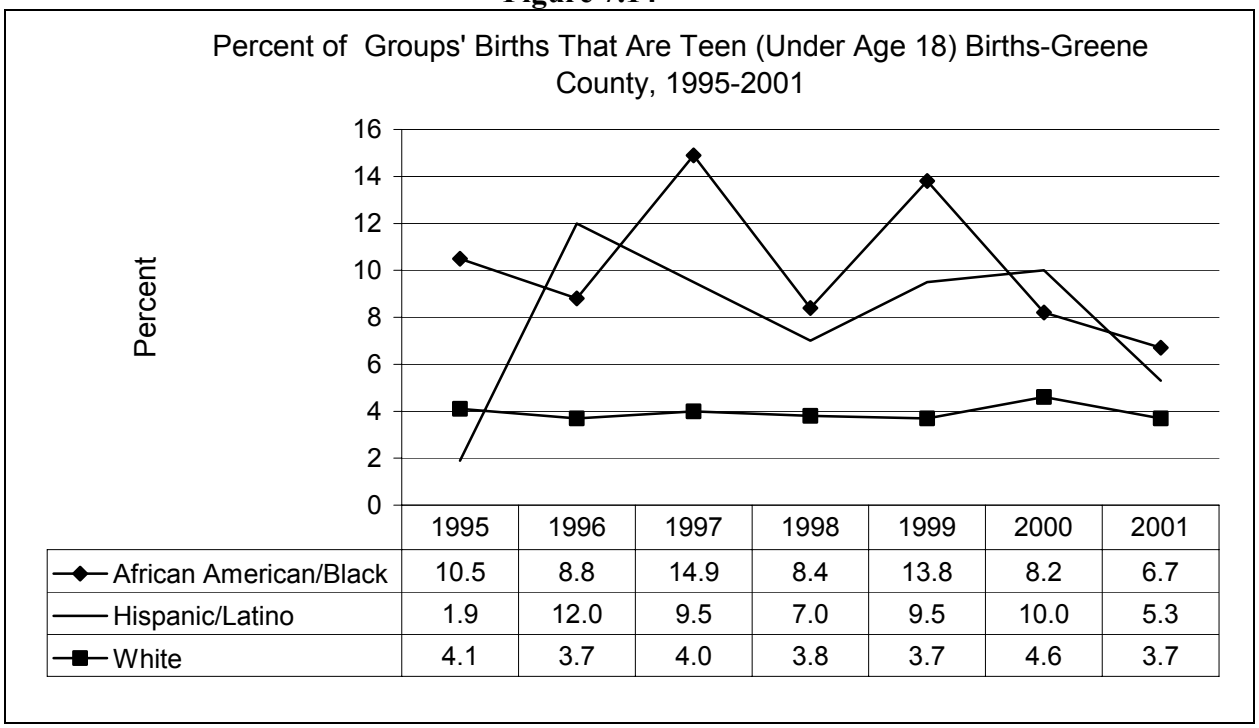
Figure 7.13



	1995	1996	1997	1998	1999	2000	2001
African American/Black	35.8	26.9	49.3	31.9	49.3	31.4	26.9
Hispanic/Latino	4.7	28.3	28.3	33.0	33.0	28.3	18.9
White	14.7	13.3	14.0	13.9	13.6	16.6	12.8

Source: Missouri Department of Health and Senior Services
*Rate based on year 2000 population total for 12 to 17 year old females

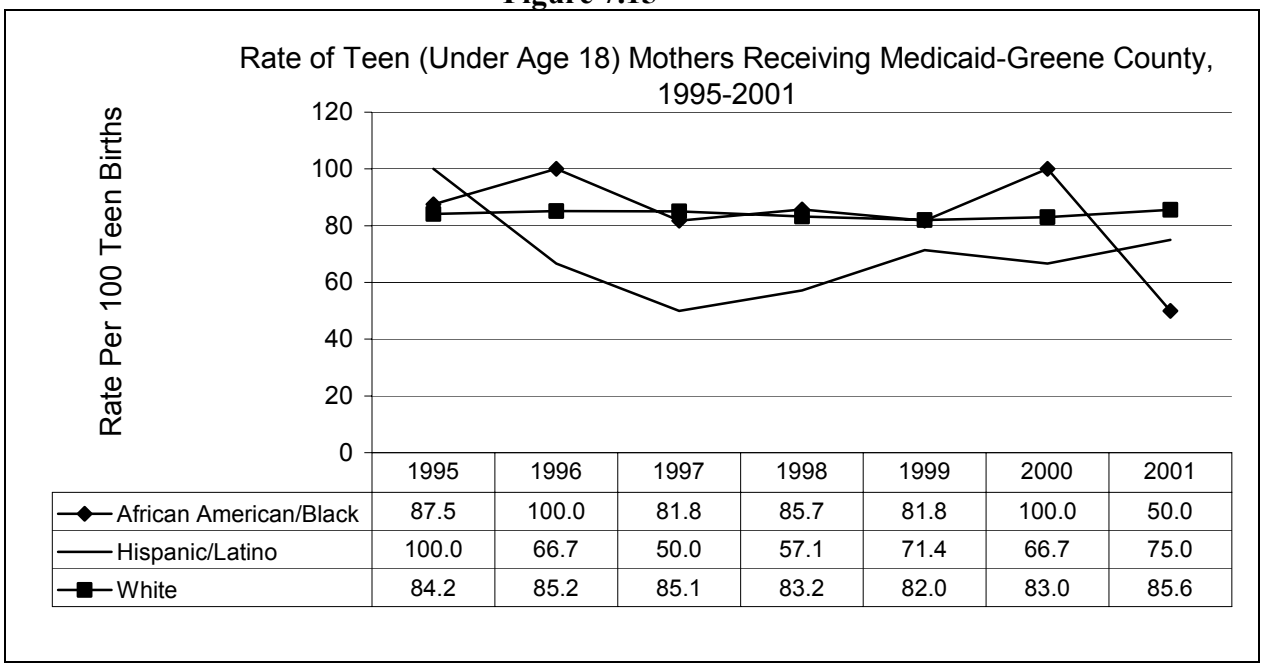
Figure 7.14



	1995	1996	1997	1998	1999	2000	2001
African American/Black	10.5	8.8	14.9	8.4	13.8	8.2	6.7
Hispanic/Latino	1.9	12.0	9.5	7.0	9.5	10.0	5.3
White	4.1	3.7	4.0	3.8	3.7	4.6	3.7

Source: Missouri Department of Health and Senior Services

Figure 7.15



	1995	1996	1997	1998	1999	2000	2001
African American/Black	87.5	100.0	81.8	85.7	81.8	100.0	50.0
Hispanic/Latino	100.0	66.7	50.0	57.1	71.4	66.7	75.0
White	84.2	85.2	85.1	83.2	82.0	83.0	85.6

Source: Missouri Department of Health and Senior Services

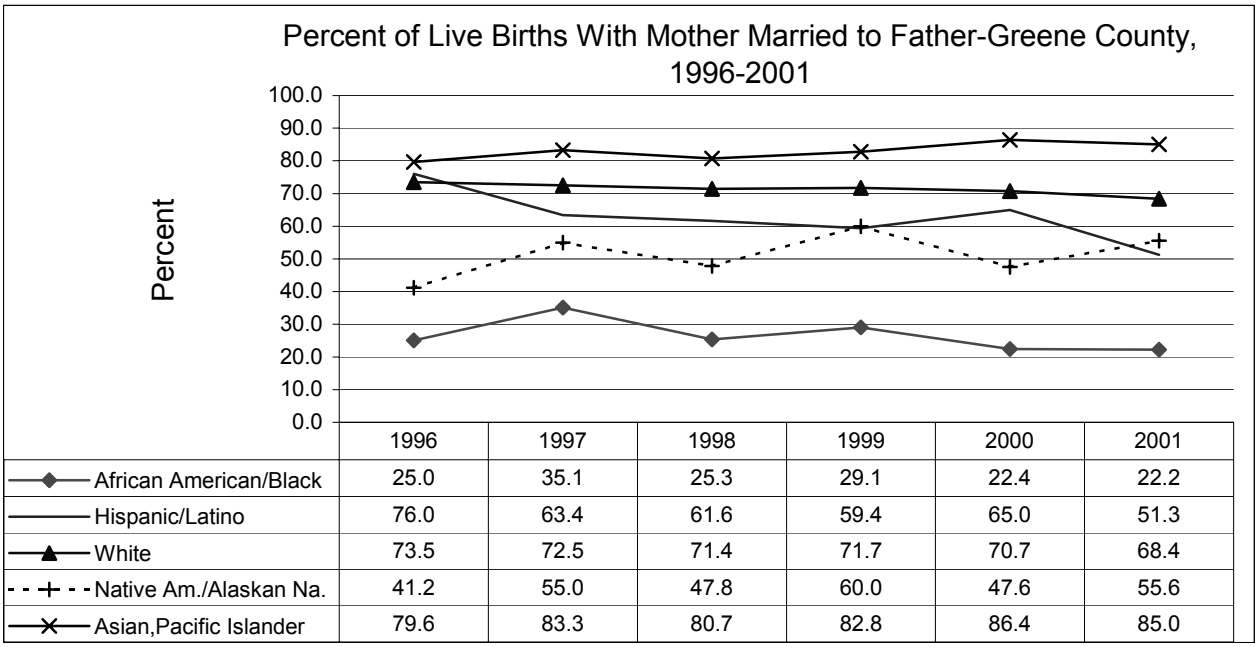
The rates presented in Figure 7.15, indicates that the overwhelming majority of teen mothers require Medicaid assistance for covering the costs of health care services. Two trends of particular interest are:

- Hispanic/Latino teen mothers are less likely to utilize Medicaid
- The rate of African American/Black teen mothers utilizing Medicaid dropped dramatically in 2001

The percentage of new mothers who were married is illustrated in Figure 7.16. Since 1996, the percentage of African American/Black mothers who were married has continued to be the lowest of all groups. Hispanic/Latino mothers who were married, has also been decreasing overall since 1996, with 51.3% of Hispanic/Latino mothers being married in 2001.

National data examining married couple families demonstrated an increasing trend in the number of African American/Black married couple families from the end of the 1990s to 2002. In 2002, 47.9% of African American/Black households were married couple families, and 43.4 % were single mother families (Harrison. 2003).

Figure 7.16



	1996	1997	1998	1999	2000	2001
African American/Black	25.0	35.1	25.3	29.1	22.4	22.2
Hispanic/Latino	76.0	63.4	61.6	59.4	65.0	51.3
White	73.5	72.5	71.4	71.7	70.7	68.4
Native Am./Alaskan Na.	41.2	55.0	47.8	60.0	47.6	55.6
Asian,Pacific Islander	79.6	83.3	80.7	82.8	86.4	85.0

Source: Missouri Department of Health and Senior Services

Table 7.9

Birth Characteristics-Greene County, 1997-2001					
	African American/Black	**Hispanic/ Latino**	**White**	**Native American/Alaskan Native**	**Asian, Pacific Islander**
Total Births	418	372	14,631	97	289
Infant Mortality Rate Per 1,000 Live Births (1998-2002)	27.3	--	6.9	--	--
Percentages					
Inadequate Prenatal Care	18.7	15.1	6.3	18.6	13.5
Low Birth Weight and Full Term Births	6.5	1.6	2.5	3.1	2.1
Mother Married to Father	26.6	59.9	71.0	52.6	83.7
Mother More Than 20% Overweight	37.3	30.6	31.3	34.0	8.7
Mother on Food Stamps	38.3	17.2	13.6	30.9	6.2
Mother on Medicaid	76.3	49.2	42.9	74.2	39.1
Mother on WIC	66.5	55.9	39.9	60.8	35.6
No Prenatal Care	2.2	1.3	0.6	2.1	1.4
Prenatal Care Began 1st Trimester	75.1	78.5	89.5	74.2	81.7
Smoking During Pregnancy	21.1	8.9	19.5	35.1	5.2
Child Spacing Less Than 18 Mo.	9.6	8.9	5.7	10.3	5.2

Source: Missouri Department of Health and Senior Services

Chronic Disease

The impact of chronic diseases is examined in the following tables. Tables 7.10 and 7.11 present mortality data from 1990 to 2002 for the African American/Black, Hispanic/Latino, and White populations. In all groups, cancer accounted for over 20% of the deaths. In the African American/Black community, the next most prevalent causes of death included acute myocardial infarction (MI) (9.6%), cerebrovascular disease (3.8%) and diabetes (4.3%). Similarly, the next most common causes of death for the Hispanic/Latino community also included acute myocardial infarction (4.7%), cerebrovascular disease (3.8%) and diabetes (3.5%). Examination of several mortality rates indicates the disproportionate effect experienced by African Americans/Blacks.

Table 7.10

Cause of Death For Residents-Greene County, 1990-2002			
	African American/Black	Hispanic/ Latino	White
Total Deaths (All Causes Including Those Not Listed)	737	254	13,378
Percentage of Group's Total Deaths:			
Acute Myocardial Infarction (Heart Attack)	9.6	4.7	11.8
Atherosclerotic Cardiovascular Disease	0.4	0.0	1.0
Heart Failure	1.6	0.4	2.3
Hypertensive Heart Disease (Heart and Renal Included)	1.0	0.4	0.6
Tuberculosis	0.3	0.0	0.1
Diabetes	4.3	3.5	2.3
Alzheimers	1.1	0.8	1.9
Cerebrovascular Disease	3.8	2.7	8.4
Atherosclerosis	0.4	0.8	0.5
Emphysema	0.4	0.8	0.6
Asthma	0.1	0.4	0.2
Alcoholic Liver Disease	0.3	1.6	0.4
Cancer (Total)	23.7	22.0	22.8
Throat, Bronchus, and Lung	7.6	8.3	7.2
Colon/Rectum/Anus	2.4	2.0	2.2
Breast	0.7	0.8	1.6
Prostate	2.2	0.8	1.2
Renal Failure	2.0	0.0	1.2
Suicide	1.1	1.6	1.4
Homicide	1.2	1.2	0.4
Rates Per 100,000 For Selected Diseases:			
Cancer (Total)	462.9	1.9	205.4
Throat, Bronchus, and Lung	153.7	**	65.2
Diabetes	85.4	**	20.2
Heart Disease	422.2	1.3	269.7
Cerebrovascular Disease (Stroke)	78.0	**	71.7
Total Mortality Rate	1,793.0	8.7	879.6

Source: Missouri Department of Health and Senior Services

** Numbers are too small to calculate a stable rate

Table 7.11 illustrates the mortality rates of Greene County residents by age. The mortality rate for African Americans/Blacks is higher among all age groups except for those between the ages of 15 to 24 years old. The surprisingly low Hispanic/Latino mortality rates may be due factors such as ethnicity reporting inconsistencies, the younger age composition of the group, or frequent relocation of some group members.

Many researchers have examined various factors that contribute to the health disparities that exist between racial groups. These researchers have also attempted to understand the fact that many of the health disparities exist even after accounting for socioeconomic status. Some evidence suggests that a contributing factor may be the socioeconomic community context in which the person lives (Robert and Lee 2002). Other researchers contend that higher morbidity and disability rates earlier in life accounts for some of the disparities that exist (Kelly-Moore and Ferraro 2004). Both of these approaches demonstrate that a complex interaction of multiple factors contribute to the overall disparities. In either case, further examinations into these health disparities are needed.

Table 7.11

Mortality Rates Per 100,000 Residents, by Age For All Causes of Death-Greene County, 1990-2002

Age	African American/Black	White	All
Under 15	161.2	73.7	76.5
15 to 24	56.8	61.5	61.6
25 to 44	883.6	162.8	180.5
45 to 64	2,188.3	698.3	717.9
65 and Over	7500.6	5,273.3	5,276.6
All Ages	1,795.6	879.8	892.2

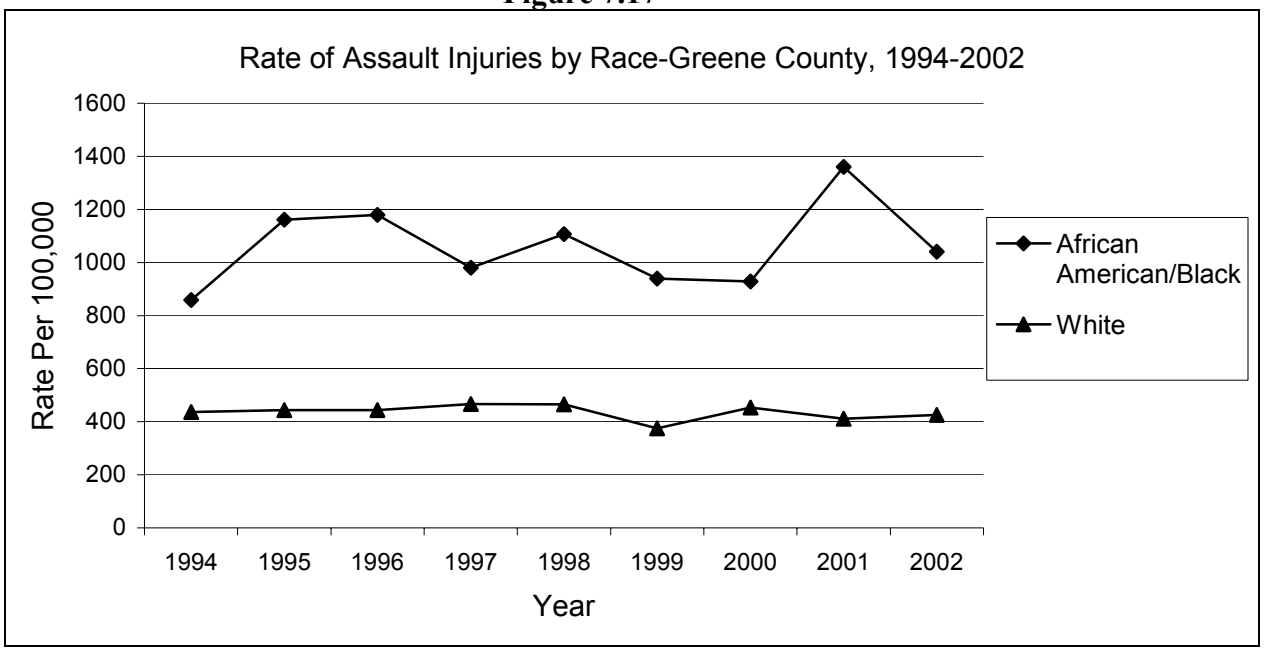
Source: Missouri Department of Health and Senior Services

Social Issues

Violence

The rate of assault injuries for Greene County is illustrated in Figure 7.17. These rates indicate that the African American/Black community is experiencing a greater rate of reported assault injuries in the county.

Figure 7.17

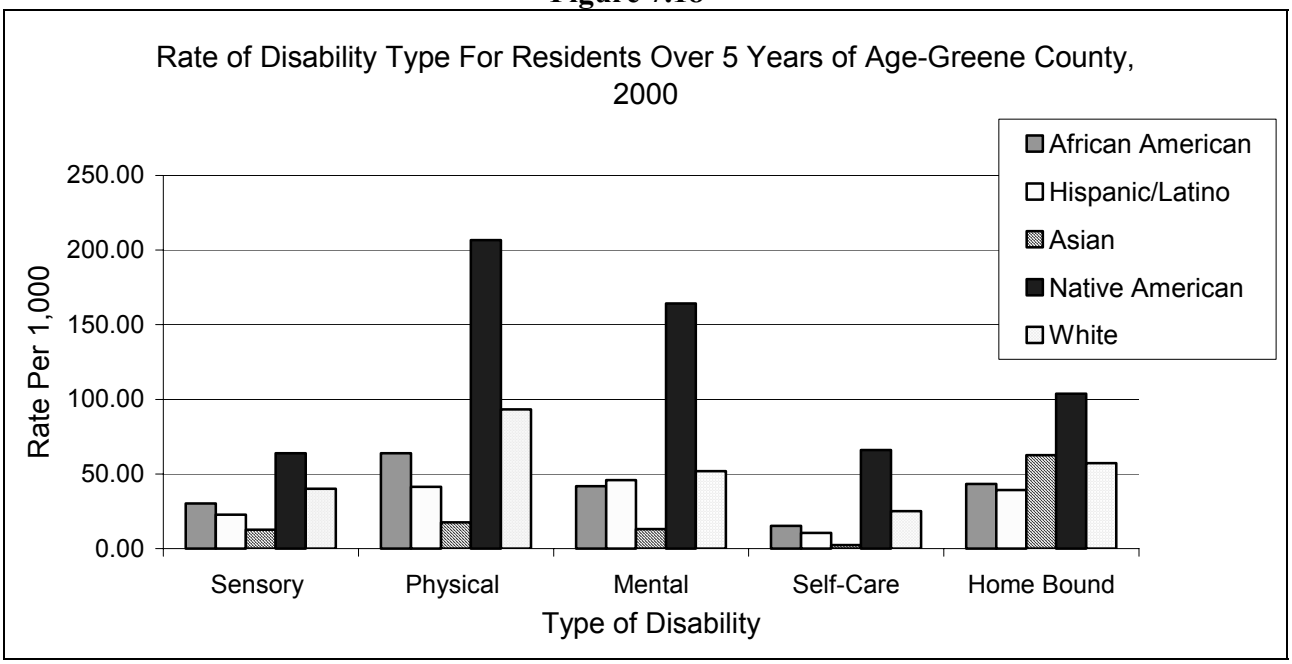


Source: Missouri Department of Health and Senior Services

Disabilities

The numbers and types of disabilities in the African American/Black and Hispanic/Latino communities are presented in Figure 7.18. According to the year 2000 Census, 344 African Americans/Blacks were disabled and 144 Hispanics/Latinos were disabled.

Figure 7.18



Source: U.S. Bureau of the Census, 2000

Sexually Transmitted Infections (STIs)

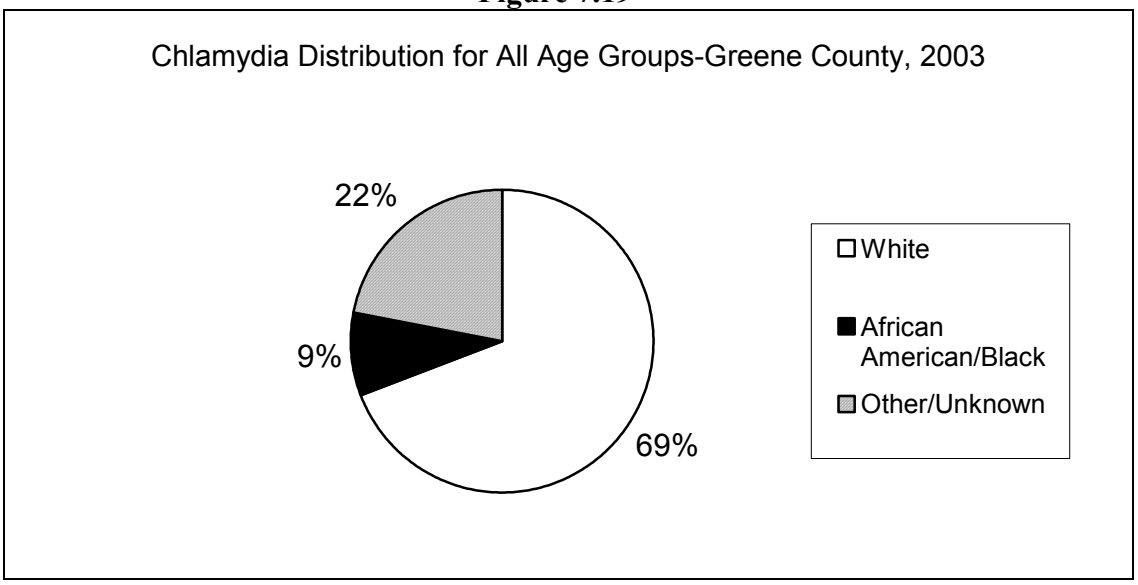
In the following figures and tables the prevalence of chlamydia and gonorrhea in the community is illustrated. Figures 7.19 and 7.20 illustrate the distribution of gonorrhea and chlamydia infections in the population. A large majority of cases are present in the White population, but the rate of infection is disproportionately higher in the African American/Black population. Table 7.12 and 7.13 shows the infection rates per 100,000 of the White and African American/Black communities. These increasing rates of infection in the community indicate that certain segments of the population are engaging in high-risk behaviors resulting in exposure and contraction of sexually transmitted infections (STIs).

Table 7.12

Chlamydia Cases-Greene County, 2003				
	Total	**White**	**African American/Black**	**Other/Unknown**
Greene County	547	378	49	120
Percent	100	69	9	22
Rate Per 100,000	224.8	168.1	903.1	

Source: Springfield-Greene County Health Department

Figure 7.19



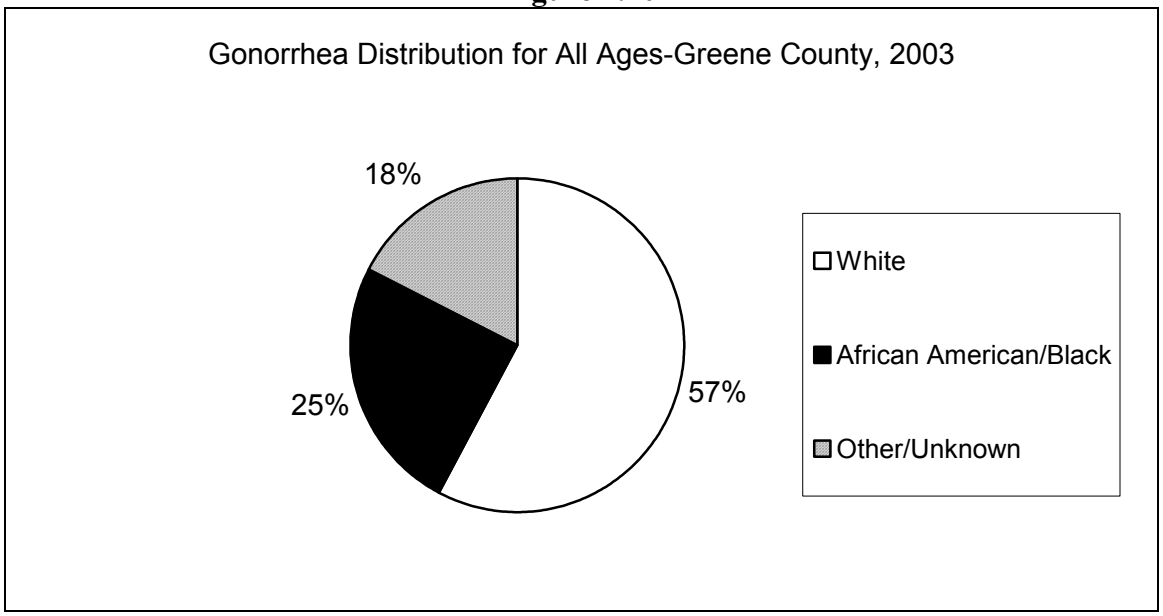
Source: Missouri Department of Health and Senior Services; n=547

Table 7.13

Gonorrhea Cases-Greene County, 2003				
	Total	**White**	**African American/Black**	**Other/Unknown**
Greene County	307	177	76	54
Percent	100	57.7	24.8	17.6
Rate Per 100,000	126.2	78.7	1400.7	

Source: Springfield-Greene County Health Department

Figure 7.20

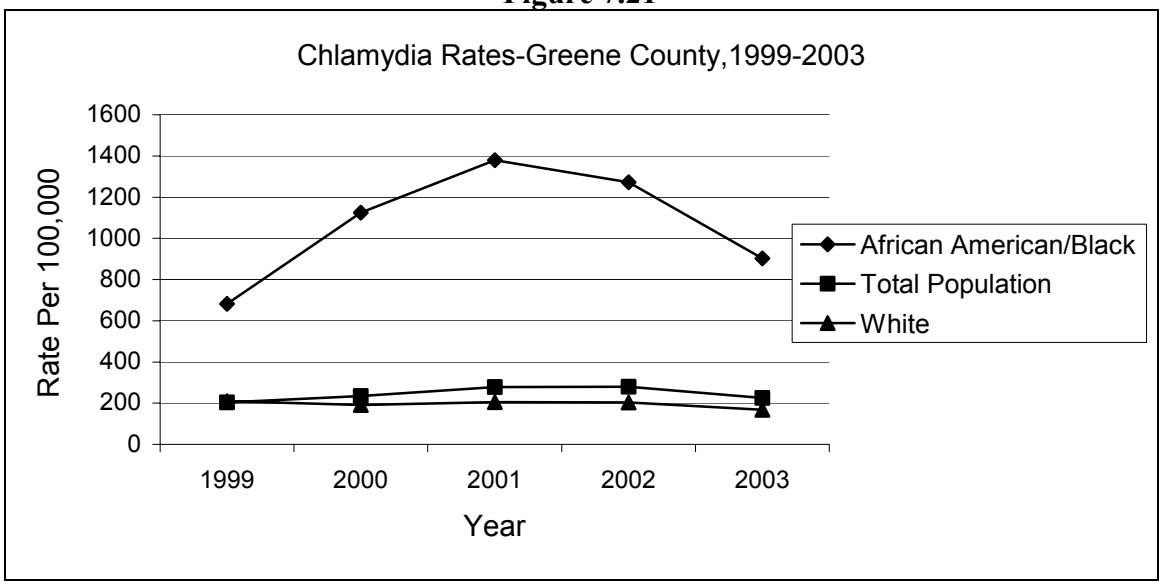


Source: Missouri Department of Health and Senior Services; n=307

When the rates for gonorrhea and chlamydia infection are plotted by race, a dramatic difference is seen in the rate of infection in the African American/Black community as compared to the White population (Figures 7.21 and 7.22). Another concern is the increase in the incidence of gonorrheal infection that has occurred since 1999.

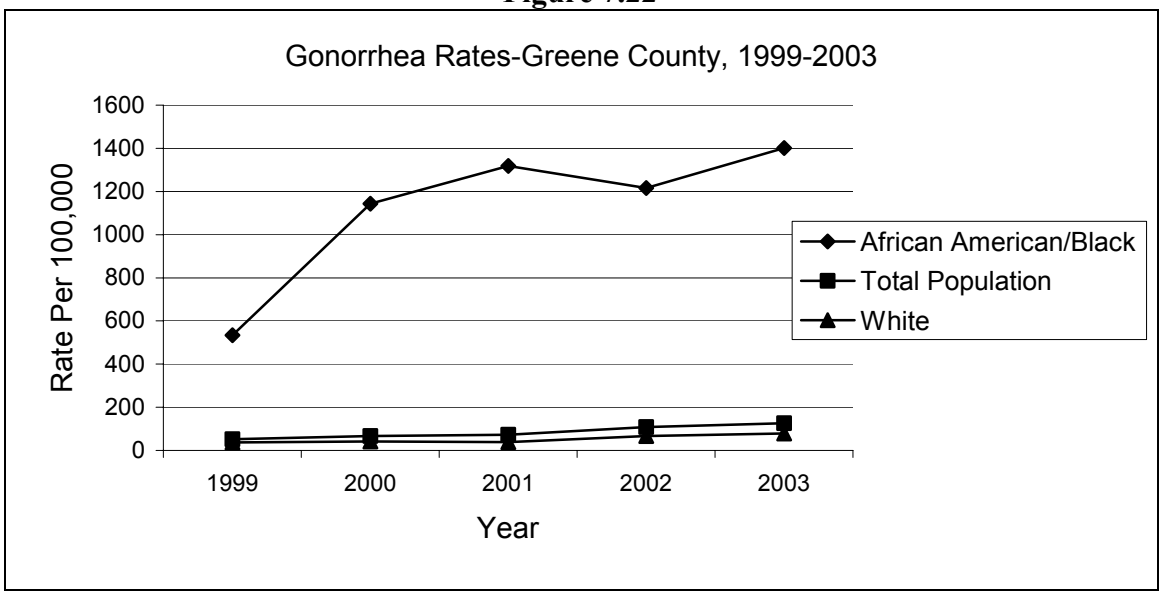
Research nationally has shown that women and African Americans/Blacks have higher incidences of STIs (Koray, Cubbins, and Billy 1995). However, any person engaging in high-risk behavior such as having multiple partners and engaging in unprotected sexual behavior will be at an increased risk of infection. Additionally, these behaviors will also increase the risk of acquiring other life threatening diseases such as HIV, Hepatitis B, Hepatitis C, and Syphillis.

Figure 7.21



Source: Springfield-Greene County Health Department
*Race data for 1999 and 2000 are incomplete due to reporting inconsistencies

Figure 7.22



Source: Springfield-Greene County Health Department
*Race data for 1999 and 2000 are incomplete due to reporting inconsistencies

Access to Health Care

Emergency room utilization is reviewed in Tables 7.14 and 7.15. Table 7.14 presents data on emergency room Medicaid patients from 1997 to 2001. The highest rates of Medicaid patient utilization of emergency room services were by the African American/Black and White populations. The lowest utilization rates were with the Native American and Hispanic/Latino groups in Greene County. Utilization of emergency room care by all residents is presented in Table 7.15. The rate of utilization in 2001 for African Americans/Blacks was significantly higher than other groups. National data has identified poverty, lack of insurance, younger age, male gender, and minority race or ethnicity as predicting factors of utilizing emergency room services as a usual source of care (Rhodes and Kennedy 2002). In addition to this, it was observed that differences existed in the medical treatment experienced by racial and ethnic groups receiving Medicaid assistance nationally. This was suggested to be one possible explanation for differences in treatment outcomes between different groups (Shields, Comstock, and Weiss 2004).

The low utilization by Hispanics/Latinos may be due to a number of reasons. This behavior was discussed during the minority health issues focus group meetings by area researchers who are interacting with Hispanics/Latinos in the region. These researchers observed that some Hispanics/Latinos preferred to seek treatment at walk-in clinics and did not like to utilize emergency rooms.

Table 7.14

Emergency Room Medicaid Patients-Greene County, 1997-2001				
	Total (1997 to 2001)	**5 Year Mean**	**2001**	**2001 Rate Per 1,000 Population**
White	111,721	18,620	22,970	102.2
African American/Black	6,337	262	1,573	289.9
Hispanic/Latino	454	76	190	42.8
Native Am./Alaska Native	366	73	12	7.6
Asian,Pacific Islander	454	76	175	60.9

Source: Missouri Department of Health and Senior Services

Table 7.15

Emergency Room Patients-Greene County, 1997-2001				
	Total (1997 to 2001)	**5 Year Mean**	**2001**	**2001 Rate Per 1,000 Population**
White	377,832	62,972	76,372	331.1
African American/Black	15,581	2,597	3,703	570.9
Hispanic/Latino	1,290	215	445	100.4
Native Am./Alaska Native	937	156	39	24.6
Asian,Pacific Islander	1,266	211	457	159.5

Source: Centers for Medicaid and Medicare Services

Table 7.16

Medicaid Participation-Greene County, 2003		
	Total	**Percent of Group's Population***
White	36,072	15.8
Black	2,090	37.3

Source: Missouri Department of Health and Senior Services
*Based on population projection for 2003

Medicaid participation for Greene County is indicated in Table 7.16. A significant proportion of the African American/Black population is utilizing Medicaid, which is a health insurance program for low-income families and individuals. This high percentage of African American/Black utilization of Medicaid may indicate differing utilization patterns between groups. Differences between the two groups, coupled with the high proportion of families in poverty, shows that a disparity in the availability of economic resources exists in our community. More research is needed to clarify this relationship as well as identify determinants of this problem.

Conclusions

Health disparities exist between the White population and minority groups in Greene County. These disparities are the result of complex interactions between numerous variables that impact health. Unfortunately, the disadvantaged members of the community, regardless of racial or ethnic identification, experience these health disparities. Poverty and all of the contributing factors such as low educational attainment, unemployment, and substance abuse that continue in the county will result in health disparities between those who have access to economic resources and those who do not. However, there continues to be inequalities in our community that cannot be explained by socioeconomic considerations alone. Questions remain, such as:

- Why do minority groups in our county experience higher proportions of poverty?
- Why aren't the rates in any of these health indicators more similar across racial and ethnic characteristics?
- How can we develop a health care system that includes more minority members?
- Why is there less utilization of prenatal care by some members of the community?
- Why is there a higher rate of African American/Black utilization of emergency rooms for care?

These questions are difficult to answer and we all need to realize that there is a lot of work to do to correct this situation. We are all members of the Greene County community and we all are affected by these health disparities regardless of race or ethnicity.

U.S. Census Bureau Definitions:

- **White:** "Refers to someone having origins in any of the original peoples of Europe, the Middle East, or North Africa."

- **Black or African American:** "Refers to people having origins in any of the Black racial groups of Africa."

- **American Indian and Alaskan Native:** "Refers to people having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment."

- **Asian:** "Refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent."

- **Native Hawaiian and Other Pacific Islander**: "Refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands."

- **Hispanic or Latino**: "Refers to people who trace origins to Spain, Mexico, and the Spanish-speaking nations of Central America, South America and the Caribbean and is an ethnic category."

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"Laughter is the shortest distance between two people."

Victor Borge

"We must learn to live together as brothers or perish together as fools."

Martin Luther King Jr

"Our lives begin to end the day we become silent about things that matter."

Martin Luther King Jr.

"Do not go where the path may lead, go instead where there is no path and leave a trail. "

Ralph Waldo Emerson

"Success is to be measured not so much by the position that one has reached in life as by the obstacles which he has overcome."

Booker T. Washington